	THE OF PERIOTEN CARE	_	VAN A HIL TUDI E. C	AON GERMAGENON .	OMB NO. 0938-0391		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		15G442	B. WING		07/30/2014		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	IR.		WING LN			
RES CAF	RE COMMUNITY A	ALTERNATIVES SE IN	JEFFERSONVILLE, IN 47130				
	1			1.001111222, 111 17 100			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
W000000							
	This visit was for	or the investigation of	W000000				
	complaint #IN0	0151755.					
	1						
	Complaint #IN(00151755 - Substantiated.					
	_						
		te deficiencies related to					
	the allegation(s)) are cited at W102,					
	W104, W122, V	W149, W154, W156 and					
	W157.						
	Survey Detect	July 28, 29 and 30, 2014					
	Survey Dates	July 28, 29 and 30, 2014					
	Facility Numbe	r: 000956					
	Provider Numb	er: 15G442					
	AIMS Number:	100244760					
	Currover Io A	nna Scott, QIDP					
	Surveyor. Jo A	illia Scott, QIDF					
		eies also reflect state					
	findings in acco	ordance with 460 IAC 9.					
	Quality Review	completed 8/12/14 by					
	Ruth Shackelfo						
	Train Shackens	iu, QIDI .					
W000102	483.410						
	GOVERNING BO	DDY AND MANAGEMENT					
	The facility must	ensure that specific					
	governing body a						
	requirements are	met.					
	Based on record	d review and interview,	W000102	W102: The facility must ensur			
		verning body failed to		that specific governing body a management requirements are			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000956

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G442	B. WIN	G		07/30/2014
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					/ING LN	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	met Corrective Action:	DATE
		ion of Participation:			(Specific) An investigation will	1
		for 4 of 4 sampled			be completed regarding the	
	`	A, B, C and D) and 4			missing medication and mone	y
		s (clients E, F, G and H).			as well as consumers being le	ft
	1 -	ody failed to exercise			unattended. All Clinical	
	1 ^ ~	on over the facility to			Supervisors will be in-serviced the initiating investigations and	
	ensure the facilit	ty implemented its			having them completed within	
	written policy ar	nd procedures to prevent			business days. All staff will be	
		s in regard to clients			in-serviced on the Abuse Negl	ect
	being left unatte	nded, missing medication			Exploitation Policy and	
	and missing mor	ney.			Procedure, Medication Audits client finances. A safe was	and
					purchased for the home to sec	cure
	Findings include	2:			all client finances. How other	
					will be identified: (Systemic)	
	Please see W122	2. The governing body			The Program Manager will foll	
	failed to meet th				up with the Clinical Supervisor	at
		lient Protections. The			least weekly to ensure that all incidents that require an	
	_	failed to ensure the			investigation are initiated and	
	1	ented written policy and			completed within 5 business	
		event neglect of clients			days. All investigations will be	
	-	_			provided to the Executive Dire	
		, G and H in regard to			upon completion for review. T Residential Manager will	ne
	_	t unattended, missing			complete a review of all client	
		money. The governing			finances and medication audit	s at
	1	onduct investigations of			least three times weekly to	
	_	eglect and theft, report the			ensure that all funds and	
	results of invest				medications are accounted for The Clinical Supervisor will rev	
		thin 5 working days and			client finances and medication	
		t corrective action to			audits at least weekly to ensur	
	address the patte	ern of theft.			that all client funds and	
					medications are accounted for	
	Please see W104	1. The governing body			Measures to be put in place:	
	failed to ensure	the facility implemented			An investigation will be comple regarding the missing medicat	
	its written policy	and procedures to			and money as well as consum	
	prevent potentia	l abuse and neglect of			being left unattended. All Clin	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G442	B. WING		07/30/2014
	ROVIDER OR SUPPLIER	TERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP CODE WING LN ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	regard to clients missing medicati governing body investigations of and theft, report investigations wi the administrator corrective action theft.	allegations of neglect		Supervisors will be in-serviced the initiating investigations and having them completed within business days. All staff will be in-serviced on the Abuse Neg Exploitation Policy and Procedure, Medication Audits client finances. A safe was purchased for the home to see all client finances. Monitoring Corrective Action: The Progr Manager will follow up with the Clinical Supervisor at least we to ensure that all incidents that require and investigation are initiated and completed within business days. All investigation will be provided to the Executi Director upon completion for review. The Residential Manawill complete a review of all cl finances and medication audit least three times weekly to ensure that all funds and medications are accounted for The Clinical Supervisor will reclient finances and medication audits at least weekly to ensure that all client funds and medications are accounted for Completion date: 08/29/14	d 5 be lect and cure g of ram e eekly ut 5 ons eve leent is at r. view of ree
W000104		DY dy must exercise general d operating direction over			
	4 of 4 sampled cand D) and 4 add	review and interview for lients (clients A, B, C litional clients (clients E, governing body failed to	W000104	W104: The governing body mexercise general policy, budge and operating direction over the facility. Corrective Action: (Specific) An investigation with the content of the	et, ne

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11

Facility ID: 000956

If continuation sheet

Page 3 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLET	TED
		15G442		LDING		07/30/20	014
			B. WIN		ADDRESS SITU STATE TIP SODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					VING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFE	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	exercise operation	ng direction over the			be completed regarding the		
	facility to ensure	e the facility implemented			missing medication and mone	•	
	1	y and procedures to			as well as consumers being le	eft	
	1	l abuse and neglect.			unattended. All Clinical	d a.a	
	prevent potentia	i abuse and negreet.			Supervisors will be in-serviced the initiating investigations and		
					having them completed within		
	Findings include	2.			business days. All staff will be		
					in-serviced on the Abuse Neg		
	Please see W149	9. The governing body			Exploitation Policy and		
	failed to exercise	e general policy and			Procedure, Medication Audits	and	
		ion over the facility to			client finances. A safe was		
		ty implemented written			purchased for the home to see	cure	
		· 1			all client finances. How othe		
	1	edure to prevent neglect			will be identified: (Systemic)		
	of clients A, B,	C, D, E, F, G and H in			The Program Manager will fol		
	regard to clients	being left unattended,			up with the Clinical Superviso		
	missing money a	and missing medications.			least weekly to ensure that all		
	The governing h	oody failed to conduct			incidents that require and investigation are initiated and		
		f allegations of neglect			completed within 5 business		
	_				days. All investigations will be		
		to report the results of			provided to the Executive Dire		
	_	the administrator within			upon completion for review.		
	5 working days	and failed to take			Residential Manager will		
	sufficient correc	tive action to address the			complete a review of all client		
	pattern of theft i	n the group home.			finances and medication audit	s at	
	•				least three times weekly to		
	This federal tag	relates to complaint			ensure that all funds and		
	#IN00151755.	relates to complaint			medications are accounted fo		
	#INUU131/33.				The Clinical Supervisor will re client finances and medication		
					audits at least weekly to ensu		
	9-3-1(a)				that all client funds and		
					medications are accounted fo	r.	
					Measures to be put in place		
					An investigation will be complete		
					regarding the missing medica		
					and money as well as consum		
					being left unattended. All Clir		
					Supervisors will be in-serviced		
					the initiating investigations an	d l	

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442	(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY COMPLETED 07/30/2014
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	07/30/2014
RES CAF	RE COMMUNITY AI	TERNATIVES SE IN		RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				having them completed within business days. All staff will be in-serviced on the Abuse Neg Exploitation Policy and Procedure, Medication Audits client finances. A safe was purchased for the home to see all client finances. Monitorin of Corrective Action: The Program Manager will follow with the Clinical Supervisor at least weekly to ensure that all incidents that require and investigation are initiated and completed within 5 business days. All investigations will be provided to the Executive Dire upon completion for review. The Residential Manager will complete a review of all client finances and medication audit least three times weekly to ensure that all funds and medications are accounted for The Clinical Supervisor will reclient finances and medication audits at least weekly to ensure that all client funds and medications are accounted for Completion date: 08/29/14	elect and cure g up ector he es at r. view n re
W000122	protections require	nsure that specific client	W000122	W122: The facility must ensu	ure 08/29/2014
	4 of 4 sampled c and D) and 4 add F, G and H), the Condition of Par	lients (clients A, B, C litional clients (clients E, facility failed to meet ticipation: Client e facility failed to	W 000122	that specific client protections met. Corrective Action: (Specific) An investigation wi be completed regarding the missing medication and mone as well as consumers being le	are II

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet Page 5 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDDIC	00	COMPL	ETED
		15G442		LDING		07/30	/2014
			B. WIN		ADDRESS CITY STATE ZID CORE	1	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
DE0.045	DE OOMMUNITY A	L TERMATINES OF IN			VING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFE	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	implement writt	en policy and procedures			unattended. All Clinical		
	to prevent negle	ect of clients A, B, C, D,			Supervisors will be in-service		
		regard to leaving clients			the initiating investigations an		
		sing money and missing			having them completed within		
					business days. All staff will b		
		e facility failed to			in-serviced on the Abuse Neg Exploitation Policy and	yı c cı	
	l	gations of allegations of			Procedure, Medication Audits	and	
	neglect and thef	t, failed to report the			client finances. A safe was		
	results of inves	tigations to the			purchased for the home to se	cure	
		ithin 5 working days and			all client finances. How other		
		fficient corrective action			will be identified: (Systemic)	
		attern of theft in the group			The Program Manager will fo		
	_	attern of their in the group			up with the Clinical Superviso		
	home.				least weekly to ensure that al	l	
					incidents that require and		
	Findings include	2 :			investigation are initiated and		
					completed within 5 business days. All investigations will be	,	
	Please see W14	9. The facility failed to			provided to the Executive Dire		
		en policy and procedure			upon completion for review.		
		ect of clients A, B, C, D,			Residential Manager will	1110	
					complete a review of all client	t	
		regard to clients being			finances and medication audi	ts at	
		missing medication and			least three times weekly to		
	missing money.	The facility failed to			ensure that all funds and		
	conduct investig	gations of allegations of			medications are accounted for		
	neglect and thef	t, failed to report the			The Clinical Supervisor will re		
	results of inves	*			client finances and medicatio		
		ithin 5 working days and			audits at least weekly to ensu that all client funds and	ııe	
		fficient corrective action			medications are accounted for	nr.	
					Measures to be put in place		
	_	attern of theft in the group			An investigation will be comp		
	home.				regarding the missing medica		
					and money as well as consur	ners	
	Please see W15	4. The facility failed to			being left unattended. All Clir		
		th investigations of			Supervisors will be in-service		
	l	nissing medication and			the initiating investigations an		
	_	ents in home unattended			having them completed within		
	1				business days. All staff will b		
	i (ciients A. B. C.	D, E, F, G and H).	1		in-serviced on the Abuse Neg	JI C Cί	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G442	B. WING		07/30/2014
			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	<u>t</u>	402 EW	/ING LN	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		RSONVILLE, IN 47130	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	report the results the administrator (clients A, B, C, Please see W157 take sufficient coaddress correctivallegations of the B, C, D, E, F, G	5. The facility failed to sof the investigations to r within 5 working days D, E, F, G and H). 7. The facility failed to prrective action to we action on substantiated eft and neglect (clients A, and H). 7. The facility failed to prective action to we action on substantiated eft and neglect (clients A, and H).		Exploitation Policy and Procedure, Medication Audits client finances. A safe was purchased for the home to see all client finances. Monitoring of Corrective Action: The Program Manager will follow u with the Clinical Supervisor at least weekly to ensure that all incidents that require and investigation are initiated and completed within 5 business days. All investigations will be provided to the Executive Dire upon completion for review. T Residential Manager will complete a review of all client finances and medication audits least three times weekly to ensure that all funds and medications are accounted for The Clinical Supervisor will reclient finances and medication audits at least weekly to ensur that all client funds and medications are accounted for Completion date: 08/29/14	cure g up up ctor he s at view up
W000149	written policies an mistreatment, neg Based on record 4 of 4 sampled c and D) and 4 add F, G and H), the implement their Abuse/Neglect/F	ENT OF CLIENTS levelop and implement d procedures that prohibit lect or abuse of the client. review and interview for lients (clients A, B, C ditional clients (clients E, facility neglected to Exploitation Policy and vent neglect of clients in	W000149	W149: The facility must dever and implement written policies and procedures that prohibit mistreatment, neglect or abuse the client. Corrective Action: (Specific) An investigation will be completed regarding the missing medication and money as well as consumers being le	e of

STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.a	00	COMPL	ETED
		15G442	A. BUII			07/30/	/2014
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
DE0 041	DE 001414111TV 1	. TEDALA TIN (EQ. QE IN)			VING LN		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		JEFFE	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	regard to clients	being left unattended,			unattended. All Clinical		
	missing medicat	ion and missing money.			Supervisors will be in-serviced		
		2 ,			the initiating investigations an		
					having them completed within		
	Findings include	.			business days. All staff will be		
					in-serviced on the Abuse Neg	iect	
	1	BDDS (Bureau of			Exploitation Policy and Procedure, Medication Audits	and	
	Developmental 1	Disability Services)			client finances. A safe was	unu	
	incident reports	were reviewed on			purchased for the home to se	cure	
	•	AM. The report dated			all client finances. How other		
	7/6/14 included	•			will be identified: (Systemic)		
		•			The Program Manager will fol	low	
	information: "[Staff #3] did finance audit				up with the Clinical Superviso	r at	
		oximately) 12 PM 7/4/14			least weekly to ensure that all		
	at kitchen table	while [staff #2] cooked			incidents that require and		
	lunch. [Staff #2]	got money out for			investigation are initiated and		
	[client G] to go	to [name of town]. On			completed within 5 business		
		imately 8 AM [staff #2]			days. All investigations will be provided to the Executive Dire		
		ce audit and get clients'			upon completion for review.		
		-			Residential Manager will	TIC	
		n outing with [staff #3]			complete a review of all client		
		the same room. \$95.00			finances and medication audit		
		g from [client B] and			least three times weekly to		
	[client A's] mon	ey bag. [Staff #2] called			ensure that all funds and		
	home manager.	Immediate preventative			medications are accounted fo		
	_	e inservices with all staff			The Clinical Supervisor will re		
		ct/Exploitation policy			client finances and medication		
	_	tion has been initiated			audits at least weekly to ensu	re	
	_				that all client funds and	r	
		." A BDDS follow-up			medications are accounted fo Measures to be put in place		
	•	7/14 indicated "The			An investigation will be compl		
	investigation has	s been turned over to the			regarding the missing medica		
	local police depa	artment for further			and money as well as consum		
	investigation."				being left unattended. All Clir		
					Supervisors will be in-serviced		
	Davious of the fe	acility investigations on			the initiating investigations an		
		icility investigations on			having them completed within		
		PM indicated there was			business days. All staff will be		
	no investigation	conducted by the facility			in-serviced on the Abuse Neg	lect	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G442	B. WIN			07/30/2014
NAME OF F	DROWIDED OF CUIDNITED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			402 EWING LN		
		TERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130	
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·	-	TAG	·	DATE
TAG	Interview with a 7/28/14 at 2:00 F had been turned department and t internal investigation indicated the fact to keep the mone action was taken. Interview with a 7/29/14 at 2:30 F could not be refuce completed investigation in the second of the mone action was performing an onticed that there	dministrative staff #2 on PM indicated the money anded without a tigation and they had not ney to client A and client cident report dated the following: "Staff a medication audit and the were two different		TAG	Exploitation Policy and Procedure, Medication Audits client finances. A safe was purchased for the home to see all client finances. Monitoring of Corrective Action: The Program Manager will follow u with the Clinical Supervisor at least weekly to ensure that all incidents that require and investigation are initiated and completed within 5 business days. All investigations will be provided to the Executive Direupon completion for review. Tresidential Manager will complete a review of all client finances and medication audits least three times weekly to ensure that all funds and medications are accounted for The Clinical Supervisor will reclient finances and medication audits at least weekly to ensure that all client funds and medications are accounted for Completion date: 08/29/14	and cure g p ctor he sat
	pack. The staff i	the consumer's bubble notified the Residential				
	_	site nurse immediately.				
		Manager and the site				
		ll consumers' bubble				
	_	ions and noted [client D]				
	I	lone missing that had				
		th her Relafen and				
		or, [client E] had one				
		let missing and had been				
	_	e of her Ropinirole,				
	[client C] had on	e Xanax missing that				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11

Facility ID: 000956

If continuation sheet

Page 9 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G442	A. BUILDING B. WING	COMPLETED 07/30/2014
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130	Е
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR TAG DEFICIENCY)	D BE COMPLETION
	was replaced with one of [client B's] Lipitor and [client B] had 13 Xanax that were missing and replaced with her Lisinopril. It was determined that none of the medications had been administered to any of the consumers. The bubble packs that had been tampered with were immediately secured, drug suspicion checklists were completed on all staff and all staff were taken for drug testing. One staff refused the drug testing and the operation is awaiting the results of the drug tests that were completed. The [name of local police department] was contacted and a message was left for [name of detective] to file a police report. The consumers' medications that were tampered with were replaced and an investigation has been initiated." A BDDS follow-up request dated 5/22/14 asked to be updated on the status of the investigation. The facility replied on 6/10/14 and indicated "The investigation has been turned over to the local authorities." Interview with administrative staff #4 on 7/28/14 at 2:00 PM indicated the incident had been turned over to the local police department and there had not been an internal investigation conducted. Administrative Staff #4 indicated the staff that refused the drug test was no		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet Page 10 of 33

l í			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G442	B. WIN	G		07/30/2014
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF P	KOVIDEK OK SUPPLIER			402 EW	ING LN	
		LTERNATIVES SE IN		<u> </u>	RSONVILLE, IN 47130	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG				TAG	BEIGERET	DATE
	longer working f	for the company.				
		cident report dated				
		ts A, B, C, D, E, F, G				
	and H indicated	"Second shift staff was				
	working 4:00 PN	If to 12:00 AM. Third				
	shift staff did no	t show up to work and it				
	was reported tha	t the second shift person				
	had left the home	e to walk down the street				
	to get third shift	staff from her apartment				
	_	ome to work, leaving the				
	•	ended. The staff				
		ion was immediately				
	placed on admin	-				
		entative measures include				
	_	all staff on Abuse/Neglect				
		was placed on leave and				
	· -	juries as a result of this				
	incident."					
	The Investigative	e Summary indicated the				
	dates of investig	ation as 6/23/14 to				
	7/25/14. The co					
		licated: "Leaving the				
		ended is substantiated."				
		formation included in the				
		ing how the facility				
		e consumers were not left				
	unattended in the					
	unauended in the	= 1utule.				
	4. The RFMS (F	Resident Account Family				
	`	ent) statements were				
		9/14 at 10:00 AM. The				
		t dated 5/1/14 to 7/29/14				
	LIVING STATELLICITI	i uaicu 3/1/14 i0 //27/14	I			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet Page 11 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 15G442	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/30/2014
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	402 EW	ADDRESS, CITY, STATE, ZIP CODE VING LN RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	indicated client A received reimbursement of funds on 6/3/14 of \$29.00, client B received reimbursement of funds on 6/3/14 of \$15.00, client F received reimbursement of funds on 6/3/14 of \$24.00, and client E received reimbursement of funds on 6/3/14 of \$10.00.			
	The internal incident report reviewed on 7/29/14 at 1:30 PM for the reimbursement was dated 3/23/14 and indicated the following: "[Staff #7] was performing a finance audit and she discovered that the clients were missing money. [Staff #7] contacted home manager. Home manager came over, counted finances and discovered that [client E] is short \$9.76, [client H] is short \$30.79, [client B] is short \$15.00, [client F] is short \$24.63, [client A] is short \$29.00, [client G] is short \$25.01."			
	The BDDS report dated 3/23/14 indicated the following: "Staff was conducting a finance audit when they discovered that the cash account for 5 individuals in the home was incorrect. It was found that [client B] was off by \$15.00, [client A] was off by \$29.00, [client F] was off by \$24.63, [client E] was off by \$9.76 and [client H] was off by \$30.79. Staff immediately contacted the RM (Regional			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet

Page 12 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G442	B. WING		07/30/2014
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE	
				WING LN	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	JEFFE	ERSONVILLE, IN 47130	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Manager) and re	ported the incident."			
	_	e Summary reviewed on			
	7/29/14 at 2:00 I	PM was dated 3/22/14 to			
	3/28/14 and indi	cated "It was reported by			
	a staff member t	hat while conducting a			
	finance audit, it	was discovered that 5			
	individuals were	missing money from			
	their home cash	account. Throughout the			
		was found that one more			
	_	nissing money as well.			
		hort \$10.00, [client B]			
), [client H] was short			
		[] was short \$24.00,			
		nort \$29.00 and [client G]			
	was short \$25.00				
	was short \$25.00	<i>)</i> .			
	Interview with a	dministrative staff #6,			
		1 7/29/14 at 2:40 PM			
		id not know why the			
		investigation were			
		in internal report, the			
		-			
	BDDS reports as reimbursed.	na me amounts			
	rennouisea.				
	5 The internal:	naidant raport datad			
		ncident report dated lewed on 7/29/14 at 2:00			
	_	indicated the following:			
	_	vork I did my controlled			
		It was supposed to be			
		mg (milligram) pills in			
	the bottle but it was only 24 Oxycodone 5				
		ttle. I called (staff #1),			
	Resident Manag	er, to tell her what I			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet Page 13 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G442	B. WIN			07/30/2014	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
550045		TED. (4.1) (50.05 lb)		402 EW			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFER	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	,	(5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPL DA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGHACT	DA	IE
	found. She called nurse."						
	771 ·	1 . 10/01/14 0/07/14					
	The investigation dated 2/21/14 - 2/27/14 indicated the following: "[Client B] was						
		•					
		odone 5 mg tablets." The					
	_	dings were as follows:					
	_	witness statements and					
		entation, it is proven that					
	1	odone 5 mg tablets					
	missing for [client B] but no way to						
	discover where they are or if anyone took						
		never went without her					
		he medication was					
		ays prior to being					
	discovered that s	even pills were					
	missing."						
	T., 4	1- CC C 7/20/14 - 4 2 00					
		taff #6 on 7/29/14 at 2:00					
		e staff that did the					
	_	s no longer working in					
	*	aff #6 indicated she did					
		orrective actions were					
	put in place.						
	Dlease see W15	The facility failed to					
		h investigations of					
	_	· ·					
	,	nissing medication and					
	_	nts in home unattended					
	(clients A, B, C,	D, E, F, G and H).					
	Dlagge see W154	The facility feiled to					
		6. The facility failed to					
	-	of the investigations to					
		within 5 working days					
	(clients A, B, C,	D, E, F, G and H).					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11

Facility ID: 000956

If continuation sheet

Page 14 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 15G442	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/30/2014
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	402 EW	ADDRESS, CITY, STATE, ZIP CODI /ING LN RSONVILLE, IN 47130	E
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
	Please see W157. The facility failed to take sufficient corrective action to address corrective action on substantiated allegations of theft and neglect (clients A, B, C, D, E, F, G and H). Review of the Abuse/Neglect/Exploitation Policy and Procedure with a revised date of 7/2/12 was conducted on 7/28/14 at 3:00 PM. The policy indicated "Community Alternatives South East staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and/or abuse shall be thoroughly investigated. Community Alternatives South East strictly prohibits abuse, neglect and/or exploitation." This federal tag relates to complaint #IN00151755. 9-3-2(a)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11

Facility ID: 000956

If continuation sheet

Page 15 of 33

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE SU	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	DDIC	00	COMPLE	TED
		15G442	A. BUII B. WIN			07/30/2	014
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				/ING LN		
RES CAF	RE COMMUNITY AL	TERNATIVES SE IN		JEFFERSONVILLE, IN 47130			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	VIDER'S PLAN OF CORRECTION (X5	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000154	/000154 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 5 of 6 allegations of neglect for 4 of 4 sampled clients (clients A, B, C and D) and 4 additional clients (client E, F, G		W000154		W154: The facility must have evidence that all alleged violations are thoroughly investigated.Corrective Action:		08/29/2014
					(Specific) An investigation wil	II	
	and H), the facil	ity failed to conduct			be completed regarding the		
	thorough investigations of missing funds,				missing medication and money		
	missing medicati	on, and staff leaving			as well as consumers being left unattended. All Clinical		
	clients in home u	ınattended.			Supervisors will be in-serviced	on	
	Findings include:				the initiating investigations and having them completed within business days. All staff will be	5 •	
	1. The facility B	DDS incident reports			in-serviced on the Abuse Negl Exploitation Policy and	ect	
	were reviewed or	n 7/28/14 at 10:45 AM.			Procedure, Medication Audits	and	
	The report dated	7/6/14 included the			client finances. A safe was		
	_	nation: "[Staff #3] did			purchased for the home to sec		
	_	approx. (approximately)			all client finances. Clients A, E	3,	
		kitchen table while [staff			E, F and H will be reimbursed missing funds. How others w		
		n. [Staff #2] got money			be identified: (Systemic) The	I .	
	-	to go to [name of			Program Manager will follow u		
		4 at approximately 8 AM			with the Clinical Supervisor at		
	_	**			least weekly to ensure that all		
		o do finance audit and get			incidents that require and		
		at for an outing with			investigation are initiated and completed within 5 business		
		aff #6] in the same room.			days. All investigations will be		
		missing from [client B]			provided to the Executive Dire	ctor	
		oney bag. [Staff #2]			upon completion for review. T	he	
	called home man	ager. Immediate			Residential Manager will		
	preventative measures include inservices			complete a review of all client	_		
	with all staff on				finances and medication audits least three times weekly to	s at	
	Abuse/Neglect/E	Exploitation policy and			ensure that all funds and		
		has been initiated into			medications are accounted for	.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet Page 16 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED)
		15G442	B. WIN			07/30/2014	4
					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			VING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		MPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
		BDDS follow-up report			The Clinical Supervisor will re client finances and medication		
	dated 7/17/14 indicated "The				audits at least weekly to ensu		
	investigation has been turned over to the				that all client funds and		
	local police department for further				medications are accounted fo	r.	
	investigation.				Measures to be put in place	:	
					An investigation will be compl		
	Review of the facility investigations on 7/28/14 at 12:30 PM indicated there was				regarding the missing medica		
					and money as well as consum		
					being left unattended. All Clir Supervisors will be in-serviced		
	no investigation conducted by the facility of the incident of missing money.				the initiating investigations an		
					having them completed within		
					business days. All staff will b		
	Interview with administrative staff #4 on				in-serviced on the Abuse Neg	lect	
	7/28/14 at 2:00 l	PM indicated the incident			Exploitation Policy and	_	
	had been turned	over to the local police			Procedure, Medication Audits	and	
	department and	there had not been an			client finances. A safe was purchased for the home to se	ouro	
	internal investig	ation conducted.			all client finances. Clients A,		
					E, F and H will be reimbursed		
	Interview with a	administrative staff #2 on			missing funds. Monitoring of		
		PM indicated the money			Corrective Action: The Progr	am	
	could not be ref	_			Manager will follow up with th		
					Clinical Supervisor at least we	,	
	_	stigation and they had not			to ensure that all incidents the	ıt	
	refunded the mo	oney for clients A and B.			require and investigation are initiated and completed within	5	
					business days. All investigation		
		ncident report dated			will be provided to the Execut		
	5/18/14 indicate	ed the following: "Staff			Director upon completion for		
	was performing	a medication audit and			review. The Residential Man		
	noticed that ther	e were two different			will complete a review of all cl		
	tablets in one of	the consumer's bubble			finances and medication audi	s at	
		notified the Residential			least three times weekly to ensure that all funds and		
	_	e site nurse immediately.			medications are accounted fo	r.	
	~	Manager and the site			The Clinical Supervisor will re		
		all consumers' bubble			client finances and medication	n	
					audits at least weekly to ensu	re	
	_	tions and noted [client D]			that all client funds and		
	had 25 Hydroco	done missing that had			medications are accounted fo	r.	

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G442			LDING	NSTRUCTION 00	(X3) DATE COMPL 07/30 /	ETED	
NAME OF P	ROVIDER OR SUPPLIER	<u>. </u>	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		402 EW JEFFER	'ING LN RSONVILLE, IN 47130		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG	been replaced will client B's] Lipit Dicyclomine tab replaced with on [client C] had on was replaced with Lipitor and [client were missing and Lisinopril. It was of the medication to any of the compacks that had be immediately see checklists were all staff were tak staff refused the operation is awa drug tests that we [name of local properties of the consumers	ith her Relafen and or, [client E] had one of her Ropinirole, he Xanax missing that the one of [client B's] and 13 Xanax that described replaced with her has determined that none has had been administered assumers. The bubble her has determined that none has had been administered assumers. The bubble her has determined that none has had been administered has been administered has been all staff and have for drug testing. One drug testing and the her ere completed. The holice department was message was left for have to file a police report. The holice department was message was left for have to file a police report. The holice department was message was left for have to file a police report. The holice department was message was left for have to file a police report. The holice department was message was left for have to file a police report. The holice department was been initiated." The request dated 5/22/14 have on the status of the her facility replied on cated "The investigation over to the local deministrative staff #4 on dem		TAG	CROSS-REFERENCED TO THE APPROPRIA		DATE
	7/28/14 at 2:00 I	PM indicated the incident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet Page 18 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G442			LDING	NSTRUCTION 00	(X3) DATE COMPL 07/30	LETED	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	_	402 EW	DDRESS, CITY, STATE, ZIP CODE ING LN RSONVILLE, IN 47130	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE
TAG	had been turned department and to internal investigated Administrative Staff that refused longer working for the staff that refused longer working for the staff that refused working 4:00 PM shift staff did now was reported that had left the home to get third shift to get them to continuously individuals unatted member in questing placed on administration of the staff of the were no injunction." The Investigative dates of investigation individuals unatted the staff of	over to the local police here had not been an ation conducted. Itaff #4 indicated the the drug test was no for the company. cident report dated ts (A, B, C, D, E, F, G "Second shift staff was If to 12:00 AM. Third to show up to work and it to the second shift person to the towalk down the street staff from her apartment me to work, leaving the ended. The staff ion was immediately instrative leave. Intative measures include the lation as a result of this essentially indicated the ation as 6/23/14 to		TAG	DEFICIENCY)		DATE
		ing how the facility consumers were not left future.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11

Facility ID: 000956

If continuation sheet

Page 19 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G442		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 07/30	LETED	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		402 EW	DDRESS, CITY, STATE, ZIP CODE ING LN SONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE	(X5) COMPLETION DATE
	Member Statemer reviewed on 7/29 RFMS statement indicated client A reimbursement of \$29.00, client B of funds on 6/3/14 received reimbursement of \$10.00. The internal incit 7/29/14 at 1:30 If reimbursement with indicated the foll "[Staff #7] was paudit and she diswere missing more contacted home manager came of discovered that [[client H] is short \$15.00, [cl [client A] is short \$25.01." The BDDS report the following: "finance audit who the cash account statement with the cash account statement with the cash account statement and the statement with the cash account statement and the statement and	of funds on 6/3/14 of received reimbursement 14 of \$15.00, client F resement of funds on and client E received of funds on 6/3/14 of the dent report reviewed on PM for the was dated 3/23/14 and lowing: performing a finance covered that the clients oney. [Staff #7]					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11

Facility ID: 000956

If continuation sheet

Page 20 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G442	B. WIN			07/30/	2014
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
DEC CAE		TEDNIATIVES SE INI		402 EW			
		LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
IAG		of by \$15.00, [client A]		IAG	,		DATE
	was off by \$29.00, [client F] was off by \$24.63, [client E] was off by \$9.76 and						
		ff by \$30.79. Staff					
		tacted the RM (Regional					
	1	ported the incident."					
	ivialiagel) and le	portou the meldent.					
	The Investigative	e Summary reviewed on					
	_	PM was dated 3/22/14 to					
	3/28/14 indicated "It was reported by a						
	staff member that while conducting a finance audit, it was discovered that 5						
		missing money from					
		account. Throughout the					
		was found that one more					
	_	nissing money as well.					
		nort \$10.00, [client B]					
), [client H] was short					
] was short \$24.00,					
		nort \$29.00 and [client					
	#G] was short \$2	-					
	#O] was short \$2	23.00.					
	Interview with a	dministrative staff #6,					
		7/29/14 at 2:40 PM					
		ff did not know why the					
		nvestigation were					
		e internal report, the					
	BDDS reports as						
	reimbursed.	id the amounts					
	Telliloursed.						
	5 The internal i	ncident report dated					
		ewed on 7/29/14 at 2:00					
		indicated the following:					
	_	work I did my controlled					
	when I got to v	voik i did my controlled					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet Page 21 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442	LDING	NSTRUCTION 00	(X3) DATE COMPL 07/30	LETED
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	 402 EW	DDRESS, CITY, STATE, ZIP CODE ING LN SONVILLE, IN 47130	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
TAG	substance count. 31 Oxycodone 5 the bottle but it w mg pill in the bo Resident Manage found. She calle The investigation indicated the foll missing 7 Oxyco investigation fine "After reviewing all other docume there are 7 Oxyco missing for [client discover where t them. [Client B] medication and t discontinued 2 d discovered that s missing." Interview with st PM indicated the investigation was that position. Sta not know what c put in place.	It was supposed to be mg (milligram) pills in was only 24 Oxycodone 5 ttle. I called (staff #1), er, to tell her what I d nurse." In dated 2/21/14 - 2/27/14 lowing: "[Client B] was adone 5 mg tablets." The dings were as follows: witness statements and entation, it is proven that odone 5 mg tablets int B] but no way to hey are of if anyone took in ever went without her he medication was ays prior to being	TAG			DATE
	#IN00151755. 9-3-2(a)	•				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet

Page 22 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G442		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/30/2014		
	ROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
W000156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 3 of 6 BDDS (Bureau of Developmental Disability Services) incident reports requiring an investigation for 4 of 4 sampled clients (clients A, B, C and D) and 4 additional clients (E, F, G and H), the facility failed to provide documentation the administrator had knowledge of the results of the investigation in 5 working days. Findings include: 1. The facility BDDS (Bureau of	W000156	W156: The results of all investigations must be reported the administrator or designate representative or to other officin accordance with State Law within five working days of the incident. Corrective Action: (Specific) All Clinical Supervisors will be in-serviced the initiating investigations, having them completed within business days and having their reviewed by the Executive Director or designated representative. How others with the identified: (Systemic) The Program Manager will follow with the Clinical Supervisor at	d ials I on 5 m		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11

Facility ID: 000956

If continuation sheet

Page 23 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G442		(X2) MULTIPLE CO	ONSTRUCTION 00	COMP	E SURVEY LETED D/2014	
	PROVIDER OR SUPPLIER		402 EV	ADDRESS, CITY, STATE, ZIP (VING LN RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Disability Sorvices	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) Least weekly to ensure	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	incident reports 7/28/14 at 10:45 incident report d (A, B, C, D, E, F) "Second shift state to 12:00 AM. To show up to work the second shift to walk down the staff from her apcome to work, let unattended. The question was impadministrative let preventative measurement with all staff on the staff was plawere no injuries incident." The Investigative 6/23/14 to 7/25/17/28/14 at 12:00 findings indicate that [staff #4] let A, B, C, D, E, F, [Staff #4] admitted consumers unatted the summary disconsumers unatted the summary disco	Abuse/Neglect policy, ced on leave and there as a result of this e Summary dated 4 was reviewed on PM. The report factual d "One staff witnessed at the consumers (clients G and H) unattended.		least weekly to ensure incidents that require investigation are initia completed within 5 but days. All investigation provided to the Execution upon completion for recompletion for recompletion for recompletion for recompletion for recompletion investigations, having completed within 5 but and having them reviet executive Director or representative. Monit Corrective Action: The Manager will follow up Clinical Supervisor at to ensure that all incidence require and investigation intiated and completed business days. All investigation in the Director upon completion of 08/29/14	and ted and ted and siness s will be titive Director eview. in place: s will be tating them siness days ewed by the designated itoring of the Program o with the least weekly lents that ion are ed within 5 estigations e Executive tion for	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet

Page 24 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
15G442			LDING		07/30/		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	l .		402 EW			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2 The DDDC re	eport dated 3/23/14					
		lowing: "Staff was					
		ance audit when they					
	_	he cash account for 5					
	`	ents A, B, E, F and H) in correct. It was found that					
		If by \$15.00, [client A] 00, [client F] was off by					
	1	was off by \$9.76 and					
		ff by \$30.79. Staff					
		tacted the RM (Regional					
		` `					
	Manager) and re	ported the incident."					
	The Investigativ	e Summary dated					
		4 was reviewed on					
		PM. The report factual					
		ed "After reviewing					
	_	nts, it was revealed that					
		re of where the money					
		discovered, however,					
	_	began to have issues					
		was not audited in and					
	<u> </u>	t properly put back in the					
	_	outing on 3/20/14.					
		exploitation by staff are					
	unable to be sub	-					
		discrepancy in their					
		reimbursed the amount					
		nances are short." The					
	conclusion indic						
	Unsubstantiated.	_					
		The summary did not					
		inistrator had been					
	marcate the auth	misuator nad occir					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11

Facility ID: 000956

If continuation sheet

Page 25 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILI	DING	00	COMPL		
15G442		B. WING	·		07/30/	/2014	
NAME OF E	PROVIDER OR SUPPLIEF		<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLITEER			402 EW	ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFER	SONVILLE, IN 47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	F	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	informed of the	outcome.					
	3. The internal i	incident report dated					
	2/21/14 was revi	iewed on 7/29/14 at 2:00					
	PM. The report	indicated the following:					
	"When I got to v	vork I did my controlled					
		It was supposed to be					
		mg (milligram) pills in					
	*	was only 24 Oxycodone 5					
		ottle. I called (staff #1),					
		er, to tell her what I					
	found. She called						
	Tourid. She cand	d hurse.					
	The Investigativ	e Summary dated					
	"	4 was reviewed on					
		PM. The report factual					
	_	ed: "After reviewing					
	witness statemer						
		it is proven that there are					
	1 *	mg tablets missing for					
		o way to discover where					
	'	yone took them. [Client					
	_	rithout her medication					
	and the medicati	ion was discontinued 2					
	days prior to bei	ng discovered that seven					
	pills were missir	ng." The conclusion					
	indicated "Alleg	ation of missing pills					
	substantiated, bu	it whereabouts					
	· ·	summary did not					
		inistrator had been					
	informed of the						
l							
	Interview with a	dministrative staff #6 on					
		PM indicated the					
							1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11

Facility ID: 000956

If continuation sheet

Page 26 of 33

i ´		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
		15G442	B. WING		07/30/2014
NAME OF P	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
				VING LN	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	JEFFE	RSONVILLE, IN 47130	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	•	mmary was forwarded to			
		r by e-mail but they did			
	<u>-</u>	cumentation indicating it			
	was received and	d reviewed.			
	_	relates to complaint			
	#IN00151755.				
	0.0.0()				
	9-3-2(a)				
W000157	483.420(d)(4)				
		ENT OF CLIENTS			
		ation is verified, appropriate			
	corrective action r		11/000157	W157: If the alleged violation	io 00/20/2014
		review and interview for	W000157	verified, appropriate corrective	
	_	Summaries reviewed for 4		action must be taken. Correcti	
	-	ents (clients A, B, C and		Action: (Specific) An	
	· ·	nal clients (clients E, F,		investigation will be completed	
	, ,	cility failed to take		regarding the missing medicat	
	appropriate corre			and money as well as consum being left unattended. All Clin	
	substantiated all	egations of theft/neglect.		Supervisors will be in-serviced	
				the initiating investigations and	d
	Findings include	:		having them completed within	
				business days. All staff will be in-serviced on the Abuse Negl	
		incident report dated		Exploitation Policy and	
		iewed on 7/29/14 at 2:00		Procedure, Medication Audits	and
	PM. The report	indicated the following:		client finances. A safe was	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet Page 27 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	a. building 00		COMPLETED	
15G442			B. WIN			07/30/2014	
		1	F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			/ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR			
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	_	vork I did my controlled			purchased for the home to seall client finances. Clients A,		
		It was supposed to be			E, F and H will be reimbursed		
	31 Oxycodone 5	mg (milligram) pills in			missing funds. How others w		
	the bottle but it	was only 24 Oxycodone 5			be identified: (Systemic) The		
	mg pill in the bo	ttle. I called (staff #1),			Program Manager will follow u		
		er, to tell her what I			with the Clinical Supervisor at		
	found. She called				least weekly to ensure that all		
	Tourid. Sile carre	a narse.			incidents that require and		
	Davious of the Ir	vestigative Summary for			investigation are initiated and completed within 5 business		
					days. All investigations will be		
		21/14 - 2/27/14 was			provided to the Executive Dire		
		28/14 at 12:00 PM. The			upon completion for review.		
	investigation wa	s for the report of client			Residential Manager will		
	B missing 7 Oxy	codone 5 mg (milligram)			complete a review of all client		
	tablets. The con	clusion of the			finances and medication audit	ts at	
	investigation ind	licated the allegation of			least three times weekly to		
		s substantiated, but			ensure that all funds and		
		known. The investigation			medications are accounted fo The Clinical Supervisor will re		
		_			client finances and medication		
	aid not include a	any corrective action.			audits at least weekly to ensu		
					that all client funds and		
	1	BDDS (Bureau of			medications are accounted fo	r.	
	Developmental 1	Disabilities Services)			Measures to be put in place	:	
	incident reports	were reviewed on			An investigation will be compl		
	7/28/14 at 10:45	AM. The BDDS report			regarding the missing medica		
		dicated the following:			and money as well as consum		
		acting a finance audit			being left unattended. All Clir Supervisors will be in-serviced		
		vered that the cash			the initiating investigations an		
					having them completed within		
		dividuals (clients A, B,			business days. All staff will be		
		ne home was incorrect. It			in-serviced on the Abuse Neg		
		client B] was off by			Exploitation Policy and		
	\$15.00, [client A	A] was off by \$29.00,			Procedure, Medication Audits	and	
	[client F] was of	f by \$24.63, [client E]			client finances. A safe was		
	was off by \$9.76	and [client H] was off			purchased for the home to se		
	1	f immediately contacted			all client finances. Clients A, E, F and H will be reimbursed		
	1 -	al Manager) and reported			missing funds. Monitoring of		

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
	15G442		B. WIN			07/30/	2014
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER				ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
TAG	the incident."	LSC IDENTIFTING INFORMATION)	 	TAG	Corrective Action: The Progra	am	DATE
	the incident.				Manager will follow up with the		
	Davian of the in	wastigativa Summany			Clinical Supervisor at least we		
		vestigative Summary 3/28/14 was conducted			to ensure that all incidents that	t	
					require and investigation are initiated and completed within	5	
		00 PM. The investigation			business days. All investigation		
	_	rt by a staff member that g a finance audit, it was			will be provided to the Executiv		
	· ·	g a mance audit, it was 5 individuals were			Director upon completion for		
		from their home cash			review. The Residential Mana will complete a review of all cli	-	
	1 -				finances and medication audits		
	1	ghout the investigation, it one more individual was			least three times weekly to		
					ensure that all funds and		
	1 -	as well. [Client E] was			medications are accounted for		
		ient B] was short \$15.00,			The Clinical Supervisor will revolute Client finances and medication		
	1 -	nort \$30.00, [client F]			audits at least weekly to ensur		
		O, [client A] was short			that all client funds and		
		nt G] was short \$25.00.			medications are accounted for		
		ings indicated "After			Completion date: 08/29/14		
	_	ss statements, it was					
		staff are aware of where					
		one. It was discovered,					
		e finances began to have					
		money was not audited					
	_	vere not properly put					
		s from the outing on					
		tions of exploitation by					
		to be substantiated. Each					
		discrepancy in their					
		reimbursed the amount					
		nances are short." The					
		ated the allegation was					
		and the allegation was					
		he summary did not					
	· ·	ective action that ensured					
	the money was replaced and the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility

Facility ID: 000956

If continuation sheet

Page 29 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPL		
15G442		A. BUI	LDING	00	07/30/		
130442		B. WIN			01/30/	2014	
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
DEC CVI		LTERNATIVES SE IN		402 EW	RSONVILLE, IN 47130		
	r				COUNTELE, IN 47 130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHOULD			
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		taken to ensure it did		TAG			DATE
	not happen agair	1.					
	2 The DDDC:						
		cident report dated					
		ts A, B, C, D, E, F, G					
		"Second shift staff was					
		I to 12:00 AM. Third					
		t show up to work and it					
		t the second shift person					
		e to walk down the street					
	_	staff from her apartment					
	_	me to work, leaving the					
	individuals unatt	ended. The staff					
	member in quest	ion was immediately					
	placed on admin	istrative leave.					
	Immediate preve	entative measures include					
	inservices with a	ll staff on Abuse/Neglect					
	policy, the staff	was placed on leave and					
	there were no inj	uries as a result of this					
	incident."						
	Review of the In	vestigative Summary					
		7/25-14 was conducted					
	on 7/28/14 at 12	:00 PM. The					
		s for the report that a					
	staff member lef	_					
		asleep. The factual					
		d "One staff witnessed					
	that (staff #4) lef						
	` ′	aff #4) admitted to					
		umers unattended during					
	her shift." The co	_					
		s "leaving the consumers					
	_	ostantiated." The					
	unattended is suf	ostantiated. The					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11

Facility ID: 000956

If continuation sheet

Page 30 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
15G442			B. WING	G		07/30/	2014
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
				402 EW			
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
	1	t include any corrective					
	action.						
	4 The DDDC in	: 4					
		ncident report dated					
		d the following: "Staff					
		a medication audit and					
		e were two different the consumer's bubble					
	-	notified the Residential					
	_	e site nurse immediately. Manager and the site					
		all consumers' bubble					
	-	tions and noted [client D]					
	1	done missing that had					
	•	ith her Relafen and					
		or, [client E] had one					
	I	let missing and had been					
	•	e of her Ropinirole, ne Xanax missing that					
		th one of [client B's]					
	_	nt B] had 13 Xanax that					
		-					
	_	d replaced with her as determined that none					
		ns had been administered					
		sumers. The bubble					
	1 -	een tampered with were					
	-	ured, drug suspicion					
	I	completed on all staff and					
		ten for drug testing. One					
		drug testing and the					
		iting the results of the					
	_	ere completed. The					
	_	olice department] was					
	contacted and a	message was left for					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet Page 31 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPL		
15G442			B. WIN	G		07/30/	2014
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
				402 EW			
		LTERNATIVES SE IN		JEFFER	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
	l =	ve] to file a police report.					
		medications that were					
	_	vere replaced and an					
		s been initiated." The					
	<u>-</u>	provide documentation					
	of corrective act	ion.					
		1.7/6/14.6					
		ated 7/6/14 for client A					
		uded the following					
	-	Staff #3] did finance audit					
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	oximately) 12 PM 7/4/14					
		while [staff #2] cooked					
		got money out for					
	, , ,	to [name of town]. On					
		imately 8 AM [staff #2]					
		ce audit and get clients					
	<u>-</u>	n outing with [staff #3]					
		the same room. \$95.00					
	total was missing	g from [client B] and					
	[client A] money	y bag. [Staff #2] called					
		Immediate preventative					
		e inservices with all staff					
	_	ct/Exploitation policy					
		tion has been initiated					
	into the incident	." A BDDS follow-up					
	report dated 7/17	7/14 indicated "The					
	investigation has	s been turned over to the					
	local police depa	artment for further					
	investigation."						
	Review of the fa	cility investigations on					
	7/28/14 at 12:30	PM indicated there was					
	no investigation	conducted by the facility					
	_	f missing money. The					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11 Facility ID: 000956

If continuation sheet Page 32 of 33

PRINTED: 09/02/2014 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE (COMPL - 07/30/	ETED
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP CO VING LN RSONVILLE, IN 47130	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Interview with a #2, #4 and #6 o indicated staff I the corrective a the investigation	o provide documentation tion. administrative staff #1, n 7/29/14 at 2:30 PM had been inserviced, but ction is not included in				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7XHR11

Facility ID: 000956

If continuation sheet

Page 33 of 33